DENTAL PAEDIATRIX
EVERY CHILD IS SPECIAL

NEW PATIENT HEALTH QUESTIONNAIRE

CHILD DETAILS:

First name: Last name:

Date of birth: Gender: Male / Female / Other

Address (no PO Box):

Suburb: Post Code:

Child lives with: Both parents Mother Father Guardian Others:

Do you require a interpreter? No Yes, what language?

Are you of Aboriginal or Torres Strait Islander origin? No Yes, Aboriginal Yes, Torres Strait Islander

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Father's Mother's Guardian's Name:

Phone: Email:

Father's Mother's Guardian's Name:

Phone: Email:

Medicare #: Child's Ref #: Exp:

Health Fund: Member #: Ref #:

Dental: Yes / No Hospital: Yes / No

Child Dental Benefits Scheme (CDBS): Yes / No

Concession card: HCC PCC

Card # Exp:

MEDICAL HISTORY

No Relevant Medical History

Allergies Asthma Epilepsy/Seizures

Behavior/learning difficulties Physical Disability Intellectual Disability

Heart / Cardiac Hepatitis /HIV Immunocompromised

Diabetes Bleeding disorders

Other medical conditions:

Medications:

In the last 2 years my child's dental / medical visits have been:

Always enjoyable Usually enjoyable Usually unpleasant Always unpleasant

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REFERRING DETAILS

☐ Dentist _____ ☐ Doctor _____ ☐ Friend/ Relative _____

☐ Self ☐ Website ☐ Internet

Reason for referral: _____

TERMS & CONDITIONS

Dental Paediatrix respects your right to privacy and considers all of the information you have provided in this form to be personal information.

To the best of my knowledge I have provided accurate information relating to my child's health, and if any changes occur I will notify the Dentist/Surgery as soon as is practicable.

I acknowledge that my child's records may be sent to their referring doctor/dentist/health professionals involved in their care.

We require total payment after each appointment. We provide a range of ways to pay for your child's dental care including cash, credit and debit card facilities.

We request that no photos or videos takes place within the surgery at any time. Please ask the permission of the operator should you wish to take a photograph.

Please let us know if you have received a letter from Medicare regarding the eligibility of Child Dental Benefits Scheme. Please note we are not a bulk billing practice.

In the very unlikely event of an emergency where an ambulance service is required, the patient/family is liable for the cost.

As a courtesy, we ask our patients to give us at least 24 hours' notice to cancel or reschedule the appointments.

☐ I have read and understood the above terms and conditions.

PATIENT PHOTO RELEASE

I authorise Dental Paediatrix to take photographs, slides and videos of my child/children's teeth, jaws, and face. I understand that the photographs, slides and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures.

I further understand that if the photographs, slides and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

☐ I do not mind if my photographs are used in any of the above stated situations.

☐ I only agree to have my teeth shown without any identifying features.

Name: _____ Date: _____

Signature: _____

Please email the completed form to **reception@dentalpx.com.au**